TASK FORCE ON HEALTH SERVICES FOR THE ELDERLY

INTERIM REPORT D

SERVICES FOR THE COGNITIVELY IMPAIRED AND NEW DIRECTIONS IN HEALTH CARE SERVICES FOR SENIORS

October, 1991

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RECOMMENDATIONS

Recommendation #1: Programming for the mentally handicapped in community residences be changed in order to permit aging in place for these individuals when they retire.

Recommendation #2: Where generic services for seniors provide appropriate services for elderly individuals with mental handicaps, these be available to them. It must be recognized that this may mean they would no longer be eligible for special services to those with mental handicaps if there is duplication. In the latter instance, it should be the choice of the individual or their guardian as to which service they receive.

Recommendation #3: Education of all levels of mental health workers provide some period of training in rural areas and as well, special mechanisms be established for recruitment of individuals in rural areas and provision of local training to them.

Recommendation #4: The Home Care Program ensure the education necessary for its workers who must deal with cognitively impaired clients.

Recommendation #5: Sponsors of Adult Day Care and Day Hospital programs ensure the education necessary for its workers who must deal with cognitively impaired clients.

Recommendation #6: The Province of Manitoba support with funding small homes for variously impaired seniors to live within the community and to the extent possible age in place. These residences should be small, housing no more than 8 to 10 residents per home. Appropriate standards, need assessments, and staffing must be developed. The care plan should encourage participation and empowerment of the residents to the extent possible.

Recommendation #7: The Dependency Assessment Chart used for PCHs be properly evaluated and any changes needed to reflect the demands of cognitively impaired residents be incorporated.

Recommendation #8: Sufficient funds be available for replacement of staff who require inservice training about cognitive impairment.

Recommendation #9: No more special care units be funded until there is clear demand and clear evidence that there are benefits and the benefits are cost effective, through impartial evaluation.

Recommendation #10: The Outreach Teams be maintained and be encouraged to take referrals from the community as well as from Personal Care Homes.

Recommendation #11: Discretionary funding be provided for each PCH to decide what positions they feel they need out of a service array of pastoral care, volunteer co-ordinator, music therapist, social workers, psychologists, activity staff, etc.

Recommendation #12: Alternative funding options be available to physicians.

Recommendation #13: A representative board structure be maintained which incorporates all of health services, including both the Department of Health and MHSC. It is to be called the Manitoba Health Board.

Recommendation #14: Special mechanisms be established to encourage co-operation between various sectors of the health care system.

Recommendation #15: A Quick Response Team be established to ensure that patients who can be treated at home are not admitted to hospital and that appropriate dollars saved from the acute care sector be transferred to the Home Care Program.

Recommendation #16: One panel for long term institutional care replace the two panel system currently in existence in Winnipeg.

Recommendation #17: Dollars start being shifted from the acute care sector to disability postponement, illness prevention, and health promotion programs, based on analyses of efficacy of actions in each of these areas.

Recommendation #18: Plans be drawn up, then implemented, that would enable seniors to seek assessment and care from a geriatric facility rather than emergency departments of acute care hospitals.

TASK FORCE ON HEALTH SERVICES FOR THE ELDERLY
INTERIM REPORT D

SERVICES FOR THE COGNITIVELY IMPAIRED AND NEW DIRECTIONS IN HEALTH CARE SERVICES FOR SENIORS

Introduction

This is the fourth and final report of the Task Force on Health Services for the Elderly. It focuses on services for seniors with cognitive impairment, spanning the continuum from continuing care to long-term institutional care. It also deals with other issues, most of which can be grouped under the rubric of new directions for the health care system. It does not deal with all possible issues for seniors. The Task Force has sat for two years, but has not exhausted all topics which should be dealt with. Therefore this report ends with a listing of a number of issues which still deserve attention.

Cognitive Impairment

Systematic data on the prevalence of various mental disorders among Manitoba's and Canada's seniors are largely unavailable. Nevertheless, there is no conclusive evidence to suggest that most mental disorders are more common among seniors than among the general population, with the exception of dementia. Current estimates suggest that around 5% - 6% of those age 65 and over suffer from dementia although some estimates are higher. There is greater consensus that among the old old, that is those age 80 and over, dementia may characterize 20% of seniors (Health and Welfare 1988).

Some seniors suffer from other mental disorders. Depression is believed to be underdiagnosed. There is concern surrounding this condition because it is often treatable, but often misdiagnosed as dementia. Other disorders may include

neuroses, personality disorders, substance abuse, and dementia disorders. Three groups are particularly important in terms of social service needs. Those with mental handicaps (mental retardation) who are aging, people who develop cognitive impairment with age, and those with mental illness who are aging.

Looking at those with mental handicaps first, both the national and Manitoba chapters of The Canadian Association for Community Living have expressed concern for individuals who are now living to old age. The services which are currently offered provide vocational workshops for younger aged adults living in the community and do not offer appropriate alternatives for those who are becoming older. Homes for those with mental handicaps come under the Office of Residential Care but their funding comes from Family Services. Family Services Department of Rehabilitation and Community Living Branch provide per diems to cover their care and service and shelter needs. As the residents age, their care levels can go beyond what can be offered under ORC. They can access professional care on a short-term basis from OCC. However, these homes do not provide programming for these individuals to retire from their workshops and remain in the same environment.

Those involved with mentally handicapped persons are interested in the integration of these individuals with generic services which seniors in general utilize but only if these services can better meet the needs of these individuals than other services. Since individuals with mental handicaps are now aging and those who live in community residences are at risk of losing their placement if they do not attend a fulltime day program (this leaves no support or supervision during the day), it is recommended that:

Recommendation #1: Programming for the mentally handicapped in community residences be changed in order to permit aging in place for these individuals when they retire.

Recommendation #2: Where generic services for seniors provide appropriate services for elderly individuals with mental handicaps, these be available to them. It must be recognized that this may mean they would no longer be eligible for special services to those with mental handicaps if there is duplication. In the latter instance, it should be the choice of the individual or their guardian as to which service they receive.

There is much concern that those with mental handicaps not be mixed with the mentally ill, unless their needs are similar. Their needs tend to be different; the goal for those with mental handicaps is optimization of their potential, whereas for some of those with mental illness the goal is the same but often the goal is resolution of the illness. Furthermore, the infrastructures for mental health and for mental retardation services are distinct and different. The mentally handicapped have gone much further in terms of developing empowerment for the individuals involved. Those with mental handicaps who live in group homes are expected to be involved as much as possible in the daily activities of the home, preparing meals etc. Furthermore there are program dollars currently attached to these residences but there are no program dollars for the Aged and Infirm (which house post-mentally ill patients) ORC facilities.

Services for the mentally ill are currently being reorganized within the Mental Health Division. Reform is in the direction of community based services in order to provide a true continuum of care. This re-organization supports the position that people cannot be discharged from institutions unless adequate and appropriate community supports are in place. It further supports the principle that services should be available as close to home as possible. The new mandate of the Mental Health Division directs this division to assume policy, planning

and fiscal responsibility for all components of the Mental Health system and put in place a well developed network of community-based services that is balanced, integrated and responsive to need (Manitoba Health 1990).

While there is much which those involved with the mentally ill can learn from the movement to assist those with mental handicaps, it is not being argued here that services for these two different groups should be integrated. It is argued, however, that many of the alternatives which have been developed for those with mental handicaps be adopted for those with mental illness, particularly in terms of community living.

Among those with mental illness, the Manitoba Health Organization (1990) states that those with mental health problems can be divided into essentially two groups. The chronically mentally ill are mostly those with schizophrenia and there are an estimated 10,000 schizophrenics in Manitoba. They group all others together, those with serious and debilitating but also controllable or curable problems which include for example anxiety, phobias, lack of coping skills, slight depression, marital or family problems. The Task Force, like the Manitoba Health Organization, supports the creation of the Regional Mental Health Councils which provide forums to bring together consumers, families, the community and service providers. There is, however, major concern about adequate recruitment for all levels of workers who work with the mentally ill in the Province as a whole and particularly in the rural areas. Two ways of insuring retention of trained personnel in rural areas are to provide part of the training in rural locations and to recruit those from rural areas and train them <u>locally</u>. The Task Force therefore recommends that:

Recommendation #3: Education of all levels of mental health workers provide some period of training in rural areas and as well, special mechanisms be established for recruitment of individuals in rural areas and provision of <u>local</u> training to them.

The increasing numbers of seniors means there are increasing numbers of individuals with mental health problems. Dementia during old age, particularly Alzheimer's Disease, has received much attention. While many of these individuals spend the last days of their lives in personal care homes, not all do and many of those who do, are cared for by family and friends within the community first. At the present time the Manitoba Chapter of the Alzheimer Society provides support groups and information referral services for family caregivers. However, the issue of providing services to families and to victims who suffer from dementia is a real one for the Manitoba Home Care Program. In studying Manitoba's Home Care Program, Kane and Kane (1985) note that workers within the system agree that those with senile dementia are the most difficult to manage at home. They argue that such clients can be maintained at home if they are not abusive or violent, do not wander at night, and have family support available. Night attendants, respite care, and adult daycare are particularly important to sustain a cognitively impaired individual at home.

Askham and Thompson (1990) report on an experimental home care program in the United Kingdom which was targeted towards maintaining dementia sufferers at home. Those who live alone, have no informal caregivers for managing necessary care, and have a high level of cognitive impairment but do not yet require 24 hour a day care can prolong their stay at home through home care programs. Maintaining these individuals at home costs more than maintaining those with lower levels of cognitive impairment at home but less than the cost of institutional care. They also report the characteristics that make it

particularly difficult to sustain demented individuals at home for any length of time: those who suffer from double incontinence, those who do not have intensive support from family and friends; those who live alone and are at risk to themselves and others of gas or fire accidents; those who do not live alone, but are very aggressive towards other household members; and those who wander persistently who live alone. While research continues in this area and there is much to be learned, it is recommended that:

Recommendation #4: The Home Care Program ensure the education necessary for its workers who must deal with cognitively impaired clients.

Recommendation #5: Sponsors of Adult Day Care and Day Hospital programs ensure the education necessary for its workers who must deal with cognitively impaired clients.

Furthermore, given that the movement which advocates on behalf of the mentally handicapped has demonstrated the viability of community living for these individuals; given that the general trend is the acceptance of the community as the preferred location for seniors to age; and given that Manitoba's licensed facilities under ORC for the Aged and Infirm are not funded to provide formal programming, it is recommended that:

Recommendation #6: The Province of Manitoba support with funding small homes for variously impaired seniors to live within the community and to the extent possible age in place. These residences should be small, housing no more than 8 to 10 residents per home. Appropriate standards, need assessments, and staffing must be developed. The care plan should encourage participation and empowerment of the residents to the extent possible.

Personal Care Homes and Cognitive Impairment

The cognitively impaired are of special concern in our long term care institutions. The Manitoba Health Organization (1990) estimates that 30.2% of such residents in 1989 had a psychiatric diagnosis. The National Collaborative Study on Dementia is estimating that the proportion with cognitive impairment in institutions is over 50%. When the results of that study are complete we will have data to know. In any event everyone agrees that the cognitively impaired resident within PCHs is becoming the norm. The average age of nursing home admission is 83 with about 80% of those admitted age 75 or more.

The Application Assessment form has a section called Dependency Assessment Chart, that assesses the following areas: (1) bathing and dressing; (2) assistance with meals; (3) ambulation/mobility/transfers; (4) elimination; (5) nursing intervention; and (6) behaviour management/support and supervision needs. The 6th section requires further clarification, to give clear and specific direction to the intent of this area. It is important to distinguish between therapeutic and maintenance types of activities/interventions. The number of cognitively impaired residents in a facility directly impacts on the staff time required to care for these individuals. Nursing assistants, who provide the vast majority of hands on care, have limited training in treatment for the cognitively impaired. The Task Force was informed the Dependency Assessment Chart was clarified somewhat to reflect need for supervision of the cognitively impaired, but we do not know how accurate the measurement is.

We were also informed that while funding does allow for replacement time for statutory holidays, vacations, etc., there is insufficient time allowed for replacement staff for inservices. This is considered essential given the changing population in our long term care institutions. It is recommended that:

Recommendation #7: The Dependency Assessment Chart used for PCHs be properly evaluated and any changes needed to reflect the demands of cognitively impaired residents be incorporated.

Recommendation #8: Sufficient funds be available for replacement of staff who require inservice training about cognitive impairment.

One response to the increasing proportion of cognitively impaired within our institutions has been the creation of two special care units (at Salem and Bethania), the creation of a psycho-geriatric assessment team at Portage La Prairie, the creation of three special care resource (outreach) teams at Taché, Bethania and Deer Lodge, and a psycho-geriatric unit at both Deer Lodge and Seven Oaks Hospital. The rationale for these units includes a recognition of the specialized problems that come with dementia, and the fact that all individuals with cognitive impairment are not necessarily disruptive to others and do not necessarily need to be segregated. Shapiro (1990) estimates that less than 10% of persons with Alzheimer's Disease are dangerous either to themselves or to other residents and even those who exhibit such behaviours do so for limited periods of time.

Special care units are designed for those with particular problems; they cost more than regular units. The question for the Task Force is: Given the changing population in all long term care institutions, is the allocation of scarce resources to special care units the most appropriate expenditure of funds? It is difficult to defend pockets of expertise when each PCH is experiencing increasing numbers of disruptive residents. While the government evaluations of the units at Salem and Bethania have been sufficiently positive for them to provide permanent funding, the Task Force was unable to obtain the response of the PCHs themselves to the special care units. The government evaluations do not

contain the responses from the PCHs and the evidence contained in the evaluation as to the benefits of the program was not conclusive. It is therefore recommended that:

Recommendation #9: No more special care units be funded until there is clear demand and clear evidence that there are benefits and the benefits are cost effective, through impartial evaluation.

If the severely cognitively impaired person is not in control of their own behaviour, then behaviour modification cannot work. Rather, staff have to take responsibility and change the environment. This can be done in select units such as at the Foyer Notre Dame Inc. It is to be noted that the Foyer Notre Dame Inc. has a special care unit without additional funding. They utilize their regular funding and the concept of generic staffing. All of these units try to provide an individualized, homelike atmosphere with staff who do what has to be done rather than specific tasks. The whole PCH has to adjust, not simply the special care unit. While it is recognized more funding is desirable for this and some of the recommendations entailed here do require additional funding, it is also the belief of Task Force members that more can be done within PCHs to create homelike, individualized units without additional funding. Examples of inexpensive changes within the PCHs include smaller spaces, adding doors, disguising doors, lines on the floors, door alarm systems, etc. Furthermore it is the belief of Task Force members that such changes will benefit those who are not cognitively impaired as well.

There was much more favourable comment on the Outreach Teams. This Program provides inservices to various facilities. The Task Force recommends that:

Recommendation #10: The Outreach Teams be maintained and be encouraged to take referrals from the community as well as from Personal Care Homes.

Relatedly, the Task Force supports the recommendation of MHO (Report on Long Term Care Manpower Education and Training Survey 1990):

> that the Departments of Health and Education compile a list of training and education programs available in Manitoba for all health care workers.
>
> that there be co-ordination and collaboration at the ministerial level and between the Departments of Health and Education as it relates to education programs for health care staff.

We understand that MARPN sponsors workshops throughout the Province for example. Over and over again the need for increased knowledge on the part of everyone was emphasized. This includes family, the public, physicians, including family physicians but also specialists, nurses, and all health care workers.

The needs of those with cognitive impairment is a timely and important issue. It is an area which requires attention immediately.

Personal Care Homes - Pastoral Care

We turn now to another issue which is particular to long term care institutions. The Task Force spent much time on the issue of pastoral care in the long term care setting, read various background materials and heard many presentations. There was agreement that the Task Force supports the importance of pastoral care in PCH's. Consensus however, could not be reached on the best means to provide this care.

At the present time, acute care hospitals with 250 beds or more have the right to chaplaincy funding. This service is also provided within the prison system. The Manitoba Interfaith Council has recommended the system used in the prisons be adapted to health care; a co-ordinator establish a system of

volunteers and train them. Volunteers would be accountable to the co-ordinator. However, in PCHs it is the Board's responsibility to determine how pastoral care is handled. Community clergy are usually involved in worship services. The issue is confounded by the fact that we have many non-secular personal care homes where spiritual needs are attended to by the church or the synagogue which sponsors the particular institution. There is concern that the civil service co-ordinator position will simply add one more layer of bureaucracy, whereas, what is really needed is the ability to make the choice to hire pastoral care as one of core alternative staff as Boards deem necessary. It is noted that the majority of Boards of PCHs have not been requesting pastoral care positions within their institutions. The Task Force does not support a co-ordinator position for all personal care homes if it is a civil service position. If such a position were to be funded it would be more appropriate if it were tied to the Manitoba Interfaith Council (MIC).

Concern arose on the Task Force that some personal care homes which are globally funded do not have an adequate service base with appropriate funding. Some of the services not adequately addressed in the global base are social work, activity staff, occupational therapist, volunteer coordinator, staff development, etc. There is support on the Task Force for providing some discretionary funding in addition to appropriate overall operating global base budgets. Therefore it is recommended that:

Recommendation #11: Discretionary funding be provided for each PCH to decide what positions they feel they need out of a service array of pastoral care, volunteer co-ordinator, music therapist, social workers, psychologists, activity staff, etc.

Still related to PCHs but on another matter, there continues to be concern about access to community services once one enters a PCH. The issue here is not one of more services but one of appropriate access of existing services for PCH residents. The issue of adequate medical care for residents in PCH's is related to method of payment. This issue, however, is not restricted to only personal care homes.

Payment for Physicians

An issue here is the fee for service structure as it currently exists for physicians. Geriatricians generally receive their income from several sources including the University, Hospitals, and fee for service through MHSC. In the fee for service system, physicians are paid disproportionately for doing procedures, not spending time with the patient. There is a disincentive for physicians to spend time on administration, on family conferences, patient education, learning the patient's history, etc. What constitutes good medical practice has evolved over time so a fee schedule which is to provide an incentive for good practice must also be constantly changing. Therefore it is recommended that:

Recommendation #12: Alternative funding options be available to physicians.

Before leaving this report there are two broad issues which relate to the health care system in its entirety which should be raised. One relates to co-ordination within the system. The other refers to evolution or change of the system itself.

The Health Care System

The need for co-ordination within the system is obvious at so many levels it is difficult to know how or where to begin. The special units of expertise to deal with cognitive impairment provide an example. As already noted there are two special care units, one psycho-geriatric assessment team, three special care resource teams also referred to as the outreach teams, and two psycho-geriatric units. The need for co-ordination between these units is necessary to ensure that persons are assessed and needs are met appropriately.

At a broader level there is little co-ordination of long term care, acute care, and home care especially in urban Winnipeg. A reorganization of long term care within the Department of Health has just been announced so that both the institutional and community sectors are responsible to one ADM. Hopefully this will allow for greater co-ordination but it is too early to tell. Presumably this will allow the transfer of funds from one sector to the other depending on the need of the client. Similarly the amalgamation of the MHSC and the Department of Health should also enable this to happen.

Even with this re-organization, Task Force members are concerned (see Report C on home care) that a representative community board structure be maintained which is accountable to the public. It is particularly important that this board structure include a mechanism to ensure that the community sector has as much power as the institutional sector in priorizing services. This is essential because the community sector is poorer in terms of resources despite the critical role it plays in the system and the number of clients it serves. As part of government, the continuing care sector competes internally with the needs of other programs, has no well organized constituency advocating on its behalf, and no access to influencing public opinion. PCHs and the Support

Services to Seniors program are also poor and lack power relative to the large hospital sector. Hospitals also have more flexibility with larger globes than any of the other sectors. Task Force members strongly believe a board structure with appropriate representation and power is essential. It is therefore recommended that:

Recommendation #13: A representative board structure be maintained which incorporates all of health services, including both the Department of Health and MHSC. It is to be called the Manitoba Health Board.

Ultimately the goal of service provision and the co-ordination of the system is to provide the most appropriate care for the individual in need. A problem with the current system is that no one is ultimately responsible for the client irrespective of where the client is located (in the community, the hospital, or the PCH). The system is not structured so the most appropriate service is provided to the individual irrespective of his or her location. For this to take place there must be regular interaction between the various sectors. There must be a recognition that the actions of one sector impact on the other. For example, discharge from hospital may empty a hospital bed but appropriate services must be in place for those individuals if they are returning to their home or for example an EPH. We have heard that the heads of geriatric services meet bi-monthly to discuss issues but they do not have a community link.

For clients' needs to be met, individual sectors cannot play "turf battles", they must look at what is best for the client within the system as a whole rather than protecting their own territory. One example is provided in Victoria, British Columbia. In an effort to promote collaboration between the hospitals and the communities to work together 3/4's of 1% of the hospital budget

(approximately 15 million dollars) was held back for hospitals to apply for projects which promote appropriate hospital utilization such as Wellness Clinics.

Another example, also from Victoria, is the Quick Response Team which is used as a mechanism to reduce demand on their emergency wards. The intent is to ensure those who can be treated at home are not admitted on an inpatient basis. It started about 4 years ago and has been evaluated. Decreased hospital costs have been attributed to this program during the last year. As a consequence, 1/2% of the hospital budget last year and 3/4% of the budget this year has been transferred from the hospital budget. However, it has been used to expand the response team so that it is now in the community longer rather than turning the dollars over to the community program which is supposed to take over after 3-7 days. The Task Force supports such a team being established here provided dollars are transferred into OCC from the start since the strategy increases demand on OCC while decreasing demand on the hospital sector. It is recommended that:

Recommendation #14: Special mechanisms be established to encourage co-operation between various sectors of the health care system.

Recommendation #15: A Quick Response Team be established to ensure that patients who can be treated at home are not admitted to hospital and that appropriate dollars saved from the acute care sector be transferred to the Home Care Program.

In order to assist in this process the separate community panels and hospital panels for long term care should be collapsed into one as currently exists within the rural areas. It is recommended that:

Recommendation #16: One panel for long term institutional care replace the two panel system currently in existence in Winnipeg.

Not only must the existing parts of the system work together and become better co-ordinated but the system must be flexible enough to evolve as societal values change, as demographic shifts take place, and as knowledge of appropriate care shifts. As others have noted (Rachlis and Kushner, 1989; Chappell, 1989; 1991) our health care system in Manitoba, like the rest of Canada, was influenced by the federal cost sharing program of the 1940's and later. Because, the institutional sector was cost shared, this is the service sector that has developed with comparatively little development in health promotion, home care support and other areas. Now that the institutional sector is well evolved, there is little room for alternatives such as the health promotion approach embraced by the WHO (see Report A of the Task Force). As Rapopport (1981) puts it, we can view the elderly and the disabled as dependent persons to be helped, socialized, trained in skills, and have their illnesses prevented, or as citizens to be assured of rights and choices. Empowerment has become a key word in the latter approach .

Empowerment generally refers to people having control over their own lives. It means having both sufficient information and the ability to take actions that will assist in their own independence. Personal empowerment, however, cannot ensure independence unless the societal structures and environment permit this action. Furthermore, as one of the Task Force members has noted, when health is deteriorating, as is frequently the case for seniors, autonomy in other areas becomes even more important. Yet our health care system does little in the way of health promotion and prevention (see Task Force Reports A and B). One of the problems is that health promotion is sometimes seen as all encompassing and as

what people, their families and their friends do on a day-to-day basis. The health care system in contrast is crisis oriented after a problem develops. It is recommended that:

Recommendation #17: Dollars start being shifted from the acute care sector to disability postponement, illness prevention, and health promotion programs, based on analyses of efficacy of actions in each of these areas.

We have another problem with our health care system. There is increasing concern that our expensive medical care system is both cost and intervention inefficient. There is increasing questioning of the way medical procedures become implemented. This is not an argument that we should do away with medical care or medicare. It is an argument that there are inefficiencies in the system and that mechanisms must be put in place to ensure that the medical care which is utilized is appropriate and effective.

As McPherson (1990) notes, there is a real difficulty in this area because, despite an increasing awareness of the problem, we lack in many instances good outcome research in order to answer questions. As the Standing Committee on Health and Welfare, Social Affairs, Seniors and Status of Women of the federal government (1989) has noted, a variety of witnesses have argued Canada's health care system is not underfunded, but that funds have to be redistributed into health promotion, disability postponement, prevention, chronic care, self help and community care. What we are arguing for is a mechanism to ensure that therapy be both medically and economically appropriate (Murphy and Matcher, 1990; Linton et. al., 1990). We have argued earlier in this report that more payment options should be available for physicians and in an earlier report that a special task force or committee examine ways in which medicine can assure that only interventions which are appropriate are utilized.

The issue here is one of an interventionist perspective versus a non-interventionist perspective unless one is certain. For seniors, it is our view that a non-interventionist perspective is more appropriate unless one knows that the intervention will be effective. The issue of intervention becomes particularly important when talking about seniors. Some individuals including geriatricians presenting to the Task Force expressed the viewpoint that there is over-servicing of elders in acute care hospitals. It is a double-edged sword, for while there is concern about over-servicing there is also concern of neglect because individuals are old (why bother, they are old anyway?). The issue is not an easy one. It includes the question of when dying begins and when it is appropriate to let the process take a natural course.

One option is to encourage as many elderly individuals as possible attend a geriatric facility for care rather than an emergency department of an acute care hospital. This does not obviate the need for all physicians to be trained in geriatric care particularly given the demographic shifts taking place. This issue is raised in an earlier Task Force report. In 1993 all psychiatrists in Manitoba will have some training in the elderly but this does not ensure that physicians will have some training in psycho-geriatrics. It is recommended that:

Recommendation #18: Plans be drawn up, then implemented, that would enable seniors to seek assessment and care from a geriatric facility rather than emergency departments of acute care hospitals.

Additional Issues

There are specific issues which concern health services to the elderly which have not been dealt with by this Task Force. The fact that this represents the last report of the Task Force is not intended as an indication that all

issues have been considered. Some are listed here which have come to the attention of the Task Force which members believe warrant immediate attention. *This list is not exhaustive.*

- Over prescribing of medication to seniors.
- Unjust or debatable surgery for seniors.
- Living wills, euthanasia, stopping treatment. We understand the Law Reform Commission is exploring at least some of these.
- The young disabled within PCH's comprise a small proportion of the total resident population (239 or 3.08% in 1989) but alternative and more appropriate placements should be explored.
- The issue of wage parity and pay equity should receive attention. PCH's have insufficient funds for parity with salaries in the acute care sector (except for RN's and LPN's).
- The mechanism for small grants for community groups be expedited. Especially where the dollars involved are small and where the community is supporting 50% or more of the project, a more efficient and timely mechanism than currently used should be found.
- The Alternative Health Care Task Force is writing a report on Palliative Care. If it does not include 'normal dying', this issue should be examined at least to ensure existing care (for geriatric persons) is acceptable.
- Efficacy of geriatric Day Hospitals should be addressed. This should include comparisons between the Day Hospitals.

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